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St. Bartholomew's Hospital Journal,

SEPTEMBER 14th, 1898.

"Æquam memento rebus in arduis
Servare mentem."—Horace, Book ii, Ode iii.

On Diagnosis.

By HENRY T. BUTLIN, D.C.L., F.R.C.S., Surgeon to the Hospital.

I. WHAT DIAGNOSIS IS;

Being the Introduction to a series of Clinical Lectures on the same subject.

GENTLEMEN,—Your diagnosis of a case is neither more nor less than your opinion on the nature of the disease. The opinion may be right or wrong, or partly right; and the frequency with which it is right will largely depend on the manner in which the opinion is formed, and on the care which is exercised.

I often wonder how the diagnosis of the future will be made. I suppose that no one will dare to make a diagnosis without the employment of special methods and special instruments; and perhaps, in the large towns at least, there will be persons whose sole business it is to diagnose the nature of disease, and not to treat it. Even now you are so accustomed to see special instruments and special methods employed, that you can scarcely conceive that a correct diagnosis can be made without them. You cannot imagine this Hospital without the Röntgen rays, without an electrical or a bacteriological department; without the cardiograph and sphygmograph; without the cystoscope, the laryngoscope, the ophthalmoscope; with only one microscope, which scarcely anyone could use with perfect confidence. You will think that I am speaking of our Hospital as it was in the Middle Ages, not as it was when I first remember it—as, indeed, I am thankful to remember it; for I cannot but think that it was an advantage to have learnt something of the art of diagnosis from men who were accustomed to practise it by careful education of the senses, especially of sight and touch, by close study and comparison of post-mortem appearances with ante-mortem symptoms, and by careful training of the mind in the weighing of evidence. I have sometimes likened these men to the mariner before the invention of the compass. Just as he made his way from port to port by careful study of the sky, and by the observation of various landmarks and their relative bearing, so the physicians and surgeons of the past made excellent diagnoses of disease by the careful observation and balancing of a hundred little signs which we are now in danger of disregarding.

We are in danger of disregarding them because we think them no longer necessary. We think we have at our command better and more certain methods, and can make a diagnosis with precision where our fathers would have been in doubt.

In some cases this may be true; but in many cases it is far from the truth. Even if it were wholly true it would only be so for those more fortunate individuals who are experts in the use of special methods, or who are

so situated as to be able to call in to their assistance at all times experts in the use of each special instrument and method. This cannot be the lot of all, or even of the large majority of those who listen to me to-day, and on them I would venture to impress the necessity of precisely similar training in diagnosis to that which was employed fifty or a hundred years ago. Special instruments and methods are, I would have you remember, a kind of double-edged tools, requiring to be used with great skill and discretion. Of the last of them, the Röntgen rays, we are just beginning to learn that skiagraphs are not so easily read as we thought they would be, but may need very cautious interpretation. And the results of microscopical and bacteriological investigation must be accepted with reserve if they are distinctly contrary to what would be expected from the general examination of the case. In the first place, there is frequently a difficulty in discovering such evidence as might certainly be expected. Quite lately I removed the profoundly tuberculous kidney of a girl from whom the urine and the discharge from an abscess in the region of the kidney had been repeatedly searched in vain for tubercle bacilli. And in the second place, they may discover what they certainly ought not to do. Tubercle bacilli were found on one occasion in the purulent urine of a lady. They were never found on any subsequent occasion, and the lady made an excellent recovery, and remains well to the present time; so that it is difficult to believe she was suffering from tubercle in the kidney. But if not, where did the tubercle bacilli come from on that one occasion on which they were discovered by a competent bacteriologist?

I doubt whether there is any greater pleasure in the medical life of a medical man than the making of a correct diagnosis in a difficult case; and this is a pleasure which can only be frequently repeated by those who have taken the pains to study the art of diagnosis. For diagnosis is not an inspiration, as some people appear to think, but an art. And although some men seem to be endowed with an aptitude for diagnosis which enables them to perform their work more quickly and more cleverly than others, there is no person in our profession who is not the better for studying the art of diagnosis just as he does any other part of his work. In order that you may do so with greater success I propose in this and some following lectures to give some general rules which may be useful, and to show how those rules apply to the diagnosis of the disease of particular parts of the body.

Scepticism and Method.

Two moods of mind are most desirable in approaching the diagnosis of every case—scepticism and method. The kind of scepticism which is most useful is that which declines to take anything for granted,—the histories which patients give of themselves, of their past diseases, of what

has been found or done by other medical men; statements by other people of the characters of material which you might see for yourself; the nature of material which appears to the naked eye to be certainly one thing, but which microscopical examination might prove to be another thing. Nothing should be taken for granted which can be proved. Patients will bring you bottles which are said to contain this or that substance. Examine the material, and be sure it is what it purports to be. A lady brought up purulent fluid from the mouth, and was operated on under the impression that it passed from the middle ear into her mouth through the Eustachian tube; but the seat of the suppuration was not revealed by the operation. Further advice was sought, and the advice was that the fluid should be carefully examined. No pus was found in it, but materials which probably came from the stomach. More than once patients have been sent to me whose urine appeared to contain large quantities of pus, and the pus was thought to come from the kidney. Microscopical examination showed that the deposit consisted of phosphates, not of pus.

Method in examination is quite as important as scepticism, for it will again and again prevent you from overlooking some part of the examination which may be essential to a thorough diagnosis. Probably a similar routine is followed by most of those who are busy in practice. That you may have a more vivid idea of such a method, imagine yourself for twenty minutes in the position of one of us. In consulting practice, patients sometimes come with a letter of introduction, sometimes without any introduction. As such a patient enters the room you notice, as a matter of routine,

(1) *The general aspect of the patient*, the sex and probable age. A certain sex and age may almost preclude some diseases, while they largely increase the liability to others. For example, you understand that your next patient is supposed to be suffering from epithelioma, and there enters the room a young lady of seventeen or eighteen years of age. You are at once prejudiced against the diagnosis of epithelioma, for it is so unlikely a disease in that sex at that age. Of course this probability of liability must not be overstrained. Quite recently a young girl suffering from epithelioma of the face has been exhibited at our consultations; she was scarcely more than a child. You notice whether the patient is young-looking or older than their age, if you happen to be aware of it. You note the carriage and elasticity, whether the individual looks well or sickly; and you may chance to see definite marks of past or present disease. It takes long to write this down, but the observation of such matters becomes so much a question of habit that it is done before the usual courtesies of a first meeting are over.

The social position of the patient ought not, one would think, to exercise an influence on the diagnosis of the case. But it undoubtedly does so. I used to think the family

attendant had an advantage over the consultant in this respect, but there is something to be said on both sides. Many years ago I saw in consultation the child of well-to-do parents, and was particularly struck with the refined appearance of the mother. The doctor asked me afterwards whether I had noticed anything peculiar about her, and I replied that she appeared to me a very refined and pleasant-looking person. What was my surprise when he informed me that she was a dipsomaniac of the worst description! On the other hand, the family attendant sometimes labours under an actual disadvantage from too intimate a knowledge of his patient. A gentleman was once sent to me that I might decide whether his tonsils should be removed. As he entered the room his forehead appeared curiously spotty, and a further examination discovered that he was suffering from active secondary syphilis. I wrote to his doctor to this effect, and added that the primary sore was even then not healed. I received a letter by return of post, in which the writer regretted his mistake, and excused it on the plea that he could not have believed that so reputable a man, whom he had known so long a time, was suffering from syphilis, particularly as he was a *churchwarden*.

(2) When the patient is seated you naturally listen to the *history* of his present and past illnesses, and inquire into the family history. A good and reliable history is of great value; but you must not be disappointed at not obtaining it. The histories given by hospital patients are for the most part defective, and you will find that our registrars generally adopt the rule of "short history, long case," on this account. Even in your dealings with educated persons you will have to exercise great caution in accepting the statements which they make. First, there is the absence of information, especially in regard to family history. I was anxious to discover a history of tubercle in the family of a man of my own age, but there was not any. Both his grandmothers had died long before he was born, and at my request he inquired (for the first time in his life) what they had died of. The answer was that both ladies had died at an early age of consumption.

Worse than the absence of information is deliberate omission or falsification. Some patients regard the man whom they consult in the light of a judge, in whose mouth lies the verdict of life and death, and before whom their cause is to be pleaded. They wish for a favorable verdict; and, in order that he may not be prejudiced against them, they deliberately withhold information which he ought to have, or even misrepresent facts. Some time ago I saw a lady with an enlarged gland. Her mother wrote to me in great trouble, asking whether I thought it could be strumous. If so, she could not understand it, as there was nothing of that kind in her family. It so happened that I knew, what was indeed notorious, that another son and daughter were actually dying of consumption. I doubt whether she intended to mislead me, but she could

not admit, even to herself, the existence of such a disease in her family.

(3) After the history follows the *examination of the affected part*, which should be as thorough and methodical for each part as it can be. Frequently a comparison of the corresponding part on the other side of the body is of the greatest assistance. I shall speak more of this in the lectures on the diagnosis of special parts of the body, and will here only again warn you not to take anything for granted, to trust as little as possible to examinations made by other persons, and to see and feel everything for yourself.

(4) A *general examination of other parts* of the body may be impossible to carry out in every case, and may seem unneedful in many cases, but the neglect of such an examination is responsible for more mistakes in diagnosis than you would believe. The signs of past tubercle, of past syphilis, and of other troubles may be present, but you may have to look for them. The patient may not be aware of their importance, scarcely indeed of their existence. A lady was sent to a consultant for his opinion on the desirability of removal of a large part of her tongue for cancer. Not taking the diagnosis for granted, and not content with examining the tongue, he examined the nose and larynx, and on inquiry, finding she had suffered from trouble in one leg, examined this also. In all these parts there was ulceration or scarring characteristic of tertiary syphilis, and the patient was rapidly cured of the "cancer" by iodide of potassium.

The making of the diagnosis.—By this time the materials are ready for the making of the diagnosis, and this may be done in more ways than one. The symptoms may belong to one particular disease, and to that disease alone. Such symptoms are called pathognomonic, and may justify a *positive* or *direct* diagnosis; but in most cases the diagnosis lies between two or more diseases, and is best arrived at by a process of exclusion. The diagnosis is *indirect*; it may be called *negative*. The reasons against each of the possible diseases are considered, and that against which the fewest or the least reasons can be set down is selected. Then the case in favour of the diagnosis of the selected disease is worked up, and all the symptoms in favour of it are marshalled to make it as strong as possible.

The doctrine of chances.—My colleague, Mr. Marsh, is fond of speaking of the value of the doctrine of chances in the making of a diagnosis. Some diseases are so much more common than other diseases, particularly under certain circumstances, as of age and sex and place, that one should be very sure of one's ground in deciding against them. I quite agree with this, and it often influences each one of us; but the doctrine of chances should not be admitted into the question until this period of the diagnosis has been reached. When the diagnosis is between a rare disease and one that is common, if the evidence is nearly balanced, the diagnosis should be unhesitatingly in favour

of the common disease. The rare disease is like a bad case in court, it requires far more evidence to prove it than a good case.

The beginning of this lecture may be regarded as a warning against the use of special instruments and methods. I hope that you will understand that it was only intended to warn you against too great reliance on them, and to show that they should be employed rather as aids to diagnosis than as the chief or only means. Now let me say that they should certainly be used in every case in which it is possible to take advantage of them. I use the two with which I am familiar (the microscope and the laryngoscope) in every case in which they may throw light on the nature of the disease; and both in the hospital and out of it I call in the aid of persons who are skilled in the use of other instruments and methods which may help in the making of a difficult diagnosis. With such aid a diagnosis which might still be a little uncertain may be absolutely proved; and I should think it wrong to neglect any means within my reach to prove the diagnosis to the hilt. I am often surprised at the neglect of special methods of examination by those who are quite able to obtain them, even in cases in which an absolutely correct diagnosis is of enormous importance to the patient. Quite lately I have been told the story of an officer who was suffering from severe ulceration of the leg. He consulted several surgeons of eminence, by whom the disease was diagnosed as cancerous, and he was urged to submit to amputation. Before doing so he showed his leg to an old friend in general practice, who suggested that a portion of the disease should be removed for microscopical examination. No cancer was found; the patient was put on large doses of iodide of potassium, and the "cancerous" ulcer quite healed. In these days such neglect of an ordinary precaution can only be regarded as a sign of overweening confidence.

In conclusion, bear always in mind that errors in diagnosis are far more frequently due to lack of care than to lack of knowledge.

II. ON THE IMPORTANCE OF SINGLE SYMPTOMS.

Intra-cranial Abscess depending on Middle Ear Disease.

GENTLEMEN,—You will wonder what there is in common in these two diseases which has induced me to place them side by side in a lecture on diagnosis. It is because they illustrate exceedingly well this section "on the importance of single symptoms." Generally we are cautious not to rely too much on a single symptom, but strive to attach to each individual symptom its proportionate value, and never to overlook a symptom, however trivial it may appear. But now I am going to show how single symptoms, which in relation to other diseases would have little value, acquire an immense importance by reason of the circumstances under which

they are observed. There are certain diseases, like those which stand at the head of this lecture, which present many and very various symptoms, and which often present symptoms which might so well belong to another or several other diseases, that it seems almost impossible to diagnose them in a difficult case. Such are intra-cranial abscess and acute septic peritonitis. Each of them may often easily be diagnosed; but the symptoms of intra-cranial abscess are sometimes so undecided, that it seems almost impossible to diagnose it from other intra-cranial diseases, and sometimes it is mistaken for a general disease which has no special relation to the brain. And the diagnosis of acute septic peritonitis is notoriously so difficult in its earlier stages, that no two surgical writers are agreed on the symptoms which should be relied on to indicate it. Yet, from a surgical point of view, there are scarcely any two diseases in which the diagnosis at an early period is likely to be so useful. The study of their symptoms is therefore quite worth your while; and I am the more pleased to direct your attention to them because I believe you will find that an examination which formerly held a high rank, but which has fallen very low in surgical estimation, deserves much more time and study than is generally bestowed upon it. It is the examination of the pulse. Formerly the rate, regularity, and character of the pulse received enormous consideration. The pulse could be set down in numbers; it afforded something definite to depend upon. With the introduction of the clinical thermometer the pulse has ceased to attract so much attention in the surgical wards. Everything is thought to depend upon the temperature, which has grown to such an importance that it has elbowed out the pulse to such an extent that in my wards, if I had not again and again insisted on it, I should find the temperature recorded in almost every case at least twice a day, and the space on the charts which is reserved for the record of the pulse quite blank. Fortunately my wishes in regard to the recording of the pulse have been respected, and I am now going to show you how important that record is in the making of a difficult diagnosis.

Intra-cranial Abscess.

As I have alluded to the points which the two diseases have in common, I shall now take them separately, and first intra-cranial abscess; and I shall take that form which is associated with disease of the middle ear, because it is the form with which I am most conversant. Under such circumstances the suppuration within the skull is usually either acute or subacute, and it often runs a very rapid course, especially during the last two or three days, or the last twenty-four hours. In such cases, too, the abscess is generally seated in the temporo-sphenoidal lobe, much less frequently in the cerebellum. It scarcely seems possible that a collection of pus of the size of a big walnut or larger should be overlooked in such a case, for it surely ought to

produce such a combination of symptoms, general and local, as could not be mistaken by a second year's student. You might easily build up the symptoms which ought to be produced by an intra-cranial abscess. For instance, they should be somewhat as follows.

Imaginary *scheme* of symptoms :

Rigor and fever.

Headache, drowsiness, and vomiting.

Optic neuritis.

Paralysis.

Curiously these symptoms, so far from being constantly present in cases of intra-cranial abscess, are very frequently absent, at least those of them on which you would be disposed to rely the most. For instance, beginning at the bottom of the list, there is frequently no paralysis. In the appendix to the *Surgical Tables* for the year 1896 Mr. Berry has given an excellent account of five cases of abscess of the brain which occurred in the Hospital during that year. In two of the five cases it is distinctly stated that there was no paralysis. Yet both patients died comatose. This may not appear so strange when it is remembered that paralysis in such cases may have to depend on actual interference with nerve-fibres passing through the brain from the cortical centres, and even a large abscess may be present without cutting off conduction through these fibres.

It is much more difficult to conceive how an abscess of considerable size can exist without producing sufficient increase of intra-cranial pressure to cause choking of the optic discs, but it is certain that this does happen, and by no means infrequently. Only in one of the five cases in the Hospital (in 1896) was there decided optic neuritis.

Headache is probably always present in a greater or less degree, and the patient is almost invariably drowsy, while vomiting is very common; but then these are symptoms which are common to so many and such various diseases, particularly to other intra-cranial diseases, that they are of comparatively little account in the diagnosis.

Intra-cranial abscess is rarely ushered in by a rigor, and so far from the temperature being raised and the pulse quickened, both pulse and temperature may be subnormal. Are there, then, no symptoms on which reliance may be placed in the diagnosis of intra-cranial abscess dependent on middle ear disease?

Constant Symptoms.

In such difficult cases I believe the best course is to seize upon the symptoms which are constant, or which occur in so many instances that they may be looked on as practically of constant occurrence. In these cases of intra-cranial abscess there are three such symptoms,—headache, drowsiness or languor, and slowness of the pulse. They are not necessarily all present at the same time in every case, although they are almost always so at a certain period of every case. The two former symptoms,

headache and languor, are of such common occurrence that they are of small import, but slowness of the pulse is, in my opinion, a symptom of the greatest value. You will find it noted in every one of the five cases in the year 1896. And although it is not present at the beginning of the formation of matter in the brain, it occurs in most cases at a comparatively early period. Slowness of the pulse and optic neuritis may be regarded as expressions of increased intra-cranial pressure. They ought both to occur in every case of abscess of the brain. But whereas many cases of intra-cranial abscess run their course without producing optic neuritis, scarcely one case terminates fatally without producing slowness of the pulse. It is therefore a more delicate symptom of intra-cranial pressure, and is on that account, and on account of its constancy, more valuable. Take the third case in the appendix:—A girl fifteen years of age was admitted into my wards on the 5th of June with otorrhoea of the left ear, and headache and vomiting of nine days' duration. There was no history of rigors or of fits; there was no paralysis, but there was a suspicion that the discs were a little larger than normal. Her temperature was 99°, and her pulse was 60. On the day after admission Mr. Lockwood, who was on duty for me, saw her, and decided to trephine at once over the temporo-sphenoidal lobe. No pus was found there. Mr. Lockwood was proceeding to search for an abscess in the cerebellum, when the patient became rapidly worse, and artificial respiration was performed. She never rallied sufficiently to permit any further examination, but died in three hours, during which artificial respiration was continuously performed. After her death a large abscess was found in the left lobe of the cerebellum.

I do not know whether you will be satisfied with a pulse-rate of 60 in the minute as evidence of slowness of the pulse, but if it be remembered that the age of the girl was fifteen, and at that age the rate of the pulse should be about 80; also that the temperature was 99°, with which there should have been a slightly quickened pulse, you will see that the pulse-rate was about twenty-five lower than it should have been. It is necessary to notice this particularly; for the expression slowness of the pulse must be understood to mean not necessarily an absolutely slow pulse, but a *relatively* slow pulse, a pulse which is slower than it ought to be when the other conditions are taken into account. For instance, a carpenter æt. 35 was admitted into a medical ward with headache and optic neuritis on the 6th of May. His temperature was 100·4°, and his pulse was 76. There was no paralysis, and at that time there was no discharge from the ear, yet he was suffering from an abscess of considerable size in the temporo-sphenoidal lobe. The abscess was not diagnosed at that time. On the following day there was slight purulent discharge from the right ear. He became worse, and his temperature fell to 97·4° while his pulse dropped sixteen beats, to 60 in the minute. On May 8th he was transferred to a surgical ward, but on the

way became so bad that artificial respiration was obliged to be performed. And although he was at once trephined, and began to breathe again, he never recovered consciousness, but died within two hours of the operation.

In this case the pulse was *relatively*, not absolutely, slow on the 6th of May. With suppuration and a temperature of 100.4° it should have been at least 86, not 76. On the 7th of May the drop of the pulse was as great in proportion as the fall in the temperature—16 beats to 3° . Even had the man been trephined on that day his life might have been saved.

I have carefully examined the records of the cases of intra-cranial abscess which have been under my care in order to discover the *absolute* rate of the pulse. It has scarcely ever fallen below 50 in any case, but has often been between 50 and 60. It may, and often does, vary in frequency during the course of twenty-four hours, even to the extent of 20 beats. I suppose the variation depends on temporary increase and diminution of intra-cranial tension; but the fact has led me to ask that the pulse-rate should be frequently taken and recorded in a doubtful case. You will find this variation of rate in the first two cases in the appendix. It varied from 70 to 54 in the first case; from 70 to 50 in the second case.

It is important, particularly from the operator's point of view, to notice the period of the disease at which the pulse becomes distinctly slower. It evidently is not so at the outset of the disease. In those cases, at least, in which the abscess is associated with middle-ear disease the commencement of the intra-cranial mischief is associated with a raised temperature and a quickened pulse; and these may continue for several or many days. During these days there surely must be increased intra-cranial pressure, but I suppose it is not sufficient to force down the pulse against the general conditions which combine to raise and keep it raised. But there comes a time when the intra-cranial disease is able to exercise its natural effect of lowering the rate of the pulse. And it may do so without causing any other distinct and obvious sign of increased intra-cranial pressure. What is more, I believe it does so sufficiently early to allow of successful treatment of the abscess. Certainly this has been so in every case that I have seen. One of them is so interesting in this respect that it is worthy of being recounted. On the 6th of May of this year (1898) a little girl about six years old was admitted into the hospital with discharge from the right ear of many years' standing, and pain in the head, giddiness, and vomiting of two or three weeks' duration. Her temperature was almost normal, her pulse about 100. The mastoid antrum and tympanic cavity were thoroughly opened that afternoon, and a small quantity of pus was let out; but the operation did not materially improve her condition, and I began to fear she was suffering from meningitis, in which opinion Mr. Cumberbatch joined me. There was nothing therefore to be

done by operation, and I watched the child growing slowly weaker day by day; when, early on the morning of the 18th of May, she had a fit, which was followed by two more fits in the course of the morning, one of which lasted nearly an hour. The eyes, in which nothing had previously been discovered, now presented decided optic neuritis. Between the fits the left hand and arm were thought to be weaker than the right. Her pulse, which had been up to this time always about 100, fell to between 60 and 70 in the minute. The sudden modification of the symptoms, especially the fall in the pulse and slight paresis of the left hand and arm, led me to trephine at once. About two ounces of dark, offensive pus were let out of the temporo-sphenoidal lobe, with immediate relief of the symptoms. Although there is not *proof* that this child was suffering from an abscess during the twelve days after the opening of the mastoid antrum, there is excellent reason for believing that she was. The absence of improvement after the first operation, and the immediate and continuous improvement after the opening of the abscess are evidence very little short of proof. Why she suddenly became so much worse on the morning of the 18th, and whether the accession of new symptoms depended on rapid increase in the size of the abscess or on encroachment on some more delicately balanced part of the brain, I do not know. But I imagine that increase in size of the abscess affords the simpler and more probable explanation. Although the slowing of the pulse was deferred until optic neuritis and loss of power were apparent, the opening of the abscess was performed in plenty of time to save the patient's life.

The Relative Value of Single Symptoms.

The value of single symptoms depends, as I pointed out in the last section, largely on their constancy. But there is a great difference in the value even of constant symptoms. Thus I set down three symptoms as being constant in cases of intra-cranial suppuration, or as occurring so commonly that they may be classed as constant,—headache, drowsiness or languor, and slowness of the pulse. But I adjudged the highest value to slowness of the pulse, on the principle that those symptoms are worth the most which are of rare occurrence in those diseases which are liable to be mistaken for the disease which is suspected. Slowness of the pulse is not common in acute or subacute inflammatory affections in any part of the body; and in cases of meningitis and thrombosis of the lateral sinus, from which intra-cranial abscess has to be diagnosed, the pulse is quick or very quick. There is at this moment a girl under my care in Lucas Ward, with the typical symptoms of thrombosis of the lateral sinus. She has a rapidly varying temperature, often very high, and the pulse corresponds almost exactly with the temperature. In the next bed to her is another girl, whose symptoms point to meningitis, depending on inflammation of the middle ear; and her pulse runs

habitually much over 100. Slowness of the pulse in intracranial affections depending on middle ear suppuration becomes, therefore, a symptom of more than usual value, because it is a constant symptom of intra-cranial suppuration, and is not a symptom of the two great affections from which suppuration has to be distinguished. I do not know whether it occurs in connection with abscess in every part of the interior of the skull, or whether it occurs earlier in connection with the abscesses of one part, later in abscesses of another part. I only know that it habitually occurs in connection with abscess of the temporo-sphenoidal lobe, of the cerebellum, and over the roof of the tympanum beneath the dura mater (subdural).

There is one symptom I have not touched on, because I really know nothing of its value. It is tenderness on palpation or percussion of the face and head. It is very highly praised by some medical men, but I suspect it is more useful in the diagnosis of tumours than of suppurations. Whether I have not applied it aright, or whether the patients have been too ill or too young, or both, to help me as they should do, I have not been able to learn much from it.

Seat of the Abscess.

This lecture is already too long to permit me to enter on the diagnosis of the side and seat of the abscess. The side you may think is always easy to determine because of the suppuration in the middle ear; but it sometimes happens that there is suppuration in both ears, and that there are no symptoms to tell on which side the abscess lies; and, as between cerebral and cerebellar abscess, there may be no differentiating symptoms. Under such circumstances we fall back on the "doctrine of chances," of which I spoke in the introductory lecture, and search for the abscess on the side on which the middle ear seems to be worse, first in the temporo-sphenoidal lobe and then in the cerebellum, in accordance with the rule that temporo-sphenoidal abscess is much more frequent than abscess of the cerebellum.

[In the study of these cases I am glad to acknowledge the assistance of my colleagues, Mr. Vernon and Mr. Cumberbatch, who have both taken a keen interest in the condition of the eye and ear in suspected abscess of the brain.]

Some Rectal Diseases.

By F. C. WALLIS, M.B., F.R.C.S., Assistant Surgeon to Charing Cross and St. Mark's Hospitals.

IV. ABSCESS AND FISTULA IN ANO.



ABSCESS in the anal region is of common occurrence, and is frequently the forerunner of fistula.

Small superficial abscesses, due to inflammation of hair-follicles, skin wounds becoming septic, and the like,

call for no special mention. They give rise to the usual symptoms, and require the same treatment here as they would elsewhere in the body.

Ischio-rectal abscesses, on the other hand, have a definite local interest, and require early recognition and active treatment for reasons beyond those that apply to ordinary abscesses.

The causes of these abscesses are, I believe, always due to some lesion in the bowel, and (contrary to the usual teaching though I know it to be) I regard all genuine ischio-rectal abscesses as produced in this manner.

The lesions which produce these abscesses are either simple fissures or ulcers, tubercular ulcers, new growths, and sometimes a high-lying non-malignant stricture.

Fissures and ulcers are by far the most common causes, and a fistula is *nearly always* the sequel in these cases.

In children threadworms are an occasional indirect cause of abscess resulting in fistula. Foreign bodies, as fish-bones and the like, by causing abrasions, or actually perforating the bowel, may produce the same disorders.

Ischio-rectal abscesses may give rise to most acute symptoms, or they may be quite slow in formation, and be in actual existence some time before the patient seeks surgical relief.

The two worst cases I have seen have both started from fissures which became septic. I detailed these in a former paper (on pruritus, fissure and simple ulcer), and I would refer my readers to them as typical cases of a bad sort.

When the abscess is of the acute variety there is no difficulty in coming to a diagnosis. The patient is quite ill, has a high temperature, and suffers great pain. On examination one buttock presents all the cardinal signs of a collection of pus, and sometimes the opposite ischio-rectal fossa is also implicated in the trouble. When the abscess is not of the acute variety a large collection of pus may exist with very little outward manifestations of its size.

The treatment of ischio rectal abscess is the same as in the case of any other abscess. A free incision is made as soon as pus is discovered, and the abscess cavity is explored with the finger, lightly plugged, and the whole area fomented for three days. As soon as the inflammation has subsided, the desirability of doing any further operation which may be necessary is considered. In opening these ischio-rectal abscesses the first incision should be made in a direction radiating from the bowel. It is often advisable to make the original incision T-shaped by making another incision at right angles to the first one at its distal end. If any subcutaneous burrowing is suspected, this should be carefully sought after, and freely laid open on a director. It is rarely necessary to ligature any vessel, and suitable plugging is all that is wanted. At St. Mark's I have never used any anæsthetic other than a local injection of eucaïne for these cases, and I find that it answers most admirably.

Most of these abscesses end in fistulæ of the complete variety, and the reason is, I believe, because they originate in an abrasion or lesion of the bowel.

Before I go into this matter it will perhaps be better to deal briefly with the main features of fistula in ano first.

The *varieties* of fistulæ are commonly described as blind internal, blind external, and complete. Now the word blind is meaningless, and in fact instead of simplifying, it only muddles the classification, such as it is, and I do not propose to use the term.

Fistulæ may be described as—

(a) Complete.

(b) Incomplete.

A *complete* fistula is one which has an external opening, an internal opening, and an intervening track. Varieties of this kind of fistulæ form what are known as the horseshoe and semi-horseshoe fistulæ.

An *incomplete* fistula may be either external or internal, according as the opening is outside, or in the bowel.

The *symptoms* of a complete fistula and of an external incomplete fistula are simple enough. They consist of an external opening which discharges pus, and which is liable to periodic attacks of pain due to local inflammation, when from any cause the pus is pent up or takes upon itself to burrow in some fresh direction.

The symptoms of an internal incomplete fistula are not so plain sailing. They generally consist of attacks of localised pain, more or less intense, which are relieved by a discharge of pus from the bowel.

On *examining* cases of fistulæ—in the complete and external varieties—an external opening will be seen somewhere in the circumference of the anus. If the tissues around this opening are palpated a hard ridge (likened very appropriately to the stem of a clay pipe) will be felt running towards the anus—in simple cases—and tracking in various directions as well in other varieties.

In the internal fistulæ this ridge cannot be so definitely felt, but if the affected side is compared with the other it will be found that it is harder, possibly painful, and a definitely outlined induration can generally be made out.

The *internal* opening in fistulæ is always difficult to locate without a certain amount of experience. But if Goodsall's rule with regard to these openings is remembered, and also the fact that they practically always are *between* the sphincters, much of the difficulty will disappear.

Goodsall's rule is briefly as follows:—all complete fistulæ which have their external openings in front of a line drawn transversely across the middle of the anus have the internal opening *immediately opposite* the external one.

Fistulæ which have the external openings behind this line have the internal opening in the *mid-line dorsally* only.

Now bearing this in mind, and also the most important fact that quite 95 per cent. of these internal openings lie *between* the sphincters, a little experience of touch to

differentiate between healthy and altered mucous membrane is all that is required to make a complete and correct diagnosis in these cases.

It has been my endeavour to make these papers as plainly practical as possible, but I hope my readers will forgive me if for a short while I become discursive with regard to one or two points already mentioned.

I have already stated that nearly all fistulæ with internal openings have these openings in a definite situation, viz. between the sphincters, and one naturally asks why this should be.

If my readers will refer to the first paper I wrote of this series, it will be seen there that I laid great stress on the frequency of simple ulcers occurring in the bowel between the sphincters. Continued experience and further careful investigation only bear out more fully what was stated then with regard to the situation of these ulcers, and also as to their great frequency. The cause of these ulcers is some injury to those valvular folds of mucous membrane which exist in this particular region of the bowel.

Given an ulcer in this neighbourhood, which for some reason becomes septic and pus-producing, an abscess ending in a fistula is the usual sequel. It may be fairly said, This is possible for complete and internal fistulæ, but what about external ones? My answer is that it is possible for the internal opening to heal, or it may be quite small, or the track may be tortuous. But practically it will be found that in most external fistulæ a probe can be passed right up to the mucous membrane.

To sum this up, I believe all genuine fistulæ originate from some lesion in the bowel, which is between the sphincters in nearly every case, and that an ischio-rectal abscess is always its forerunner.

A horseshoe or semi-horseshoe fistula may occur either anteriorly or dorsally; the majority of them are in the dorsal area.

In these cases a track will be found running in a horseshoe fashion at a varying distance from the bowel, and in all suspected cases careful palpation and probing must be undertaken, and the sinus laid thoroughly open. There is *usually* only one internal opening, and that falls in with the rule given above.

A troublesome form of internal fistula is the *submucous* one. Pain in these cases is not a prominent symptom, but there is a constant discharge of pus which varies in amount. On examination a large ulcerated opening is found, almost at times big enough to admit the point of the finger, and extending up from this is a soft elastic swelling, which is formed by the pus burrowing between the mucous and muscular coats. This variety is an exception to the rule I suggested above, but it is only a difference of degree.

Tubercular fistulæ have in common with the submucous variety a large ulcerated internal opening; they are apt to burrow deeply into the tissues, and the skin is of a livid

colour over them. The patients present the usual tuberculous appearance. It used to be stated, and is still believed by some, that a large percentage of fistulæ are due to tubercle. My experience at St. Mark's certainly does not bear this out, as will be seen by the statistics given below.

Rarely a patient may have two fistulæ with separate internal openings; there have been two such cases at St. Mark's in the last eighteen months.

Incontinence of feces is a possible result after these have been operated upon, and it is as well to bear this in mind.

Occasionally one sees a case of fistulæ which has multiple external openings. They are complete fistulæ which have tracked subcutaneously, and openings have occurred at various points.

Before discussing the treatment of these fistulæ and abscesses, about which there is a great deal to say, it will perhaps be as well to enumerate here the various cases of fistula which have come under my care and the care of my colleagues at St. Mark's Hospital since January, 1897. I am much indebted to Mr. Cudmore for helping me in this matter.

CASES OF FISTULA ADMITTED DURING 1897.

	Male.	Female.	Total.
No. of cases in all	182	111	393
Fistula dextra	40	13	53
" sinistra	16	3	19
" complete horseshoe	7	3	10
Fistulæ dorsal	5	4	9
Ischio-rectal abscess	4	1	5
	72	24	96

1898 UNTIL JUNE 30TH.

	Male.	Female.	Total.
No. of cases in all	102	61	163
Fistula dextra	15	6	21
" sinistra	17	4	21
" complete horseshoe	6	3	9
Fistulæ dorsal	2	3	5
Ischio-rectal abscess	—	—	—
Fistula internal	3	2	5
" anterior	6	—	6
	49	18	67

One case suffered from incontinence—result of operation elsewhere. There were two cases of two distinct and separate fistulæ connected with bowel, one on each side of anus.

Three cases of fistula complicated with fissure.

Twelve	"	"	"	hæmorrhoids.
Six	"	"	"	phthisis.
Four	"	"	"	stricture (all women).
One	"	"	"	diabetes.

Five cases of blind internal fistula.

Two cases of recto-vaginal fistula.

One case of anterior horseshoe fistula in a woman.

Two cases of fistulæ with multiple openings—one with ten openings, the other with forty-five.

No deaths from any of the cases.

163 cases in all—152 cases cured, 11 relieved. Of these—

One suffered from diabetes.

Four suffered from phthisis.

Two left before healed.

Four cause of non-healing not stated.

CASES OF FISTULÆ NOT ADMITTED.

85 cases in all.

Eight cases of ischio-rectal abscess—one case in which there was an abscess on each side.

Thirteen cases of fistula anterior and internal opening opposite external.

Four cases of blind internal fistula.

27 cases of fistula sinistra.

23 " " dextra.

10 " " dorsalis.

Four cases noted as being due to phthisis.

Ten cases of fistula laid open, external sphincter divided, and patients cured, except in one case.

One patient was cured of fistula, and now has pruritus.

One case complicated with diabetes.

One case operated upon five years ago elsewhere has now recurred in site of old operation.

One patient with phthisis. Abscess cavity touched with lactic acid twice weekly for three months, and then fistula laid open into bowel—now almost well.

(To be continued.)

Biographical Memoirs of Dr. Pitcairn.



WE are indebted to Dr. Harry Campbell for the following interesting cutting from the *Gentleman's Magazine* for April, 1899.

DAVID PITCAIRN, M.D., F.R.S., F.A.S., Fellow of the College of Physicians of London, and Physician Extraordinary to the Prince of Wales, was the eldest son of the gallant Major John Pitcairn, of the Marines, who was killed in the attack upon Bunker's Hill in June, 1775, and Elizabeth, the daughter of Robert Dalrymple, Esq., of Annefield, in the county of Dumfries. His paternal family was one of the most ancient in Fifeshire, deriving its name from a landed possession called Pitcairn; Nisbett in his *Heraldry* says that he has seen a charter to it dated in 1417. In the course of time one of the family acquired by marriage the estate of Forther, in the same county; after which the lands of Pitcairn went off with a younger son, from whom was descended Dr. Archibald Pitcairn, of Pitcairn, justly famed as a physician, poet, wit, scholar, and mathematician. Of the elder branch Dr. David Pitcairn became the representative upon the death of his uncle, the well-known Dr. William Pitcairn, who had practised physic here for nearly half a century, and had been many years President of the College of Physicians.

Dr. David Pitcairn was born on the 1st of May, 1749, in the house of his grandfather, the Rev. David Pitcairn, minister of Dysart, in the county of Fife. When about nine or ten years old, he was sent to the High School at Edinburgh, where he remained four years; after which he went to the University of Glasgow, and prosecuted his studies there till he arrived at the age of twenty. At this period of his life he used to spend much of his leisure time with the family of the Rev. James Baillie, minister of Bothwell, in the county of Lanark, and father of the present Dr. Matthew Baillie, of London, and of the celebrated dramatic writer, Miss Johanna Baillie. During this intercourse commenced an affectionate intimacy between Dr. Pitcairn and Dr. Baillie, which afterwards, as the difference of their years became less in proportion to their whole ages, gradually changed into the warmest friendship, that continued ever after. It being now determined that he should be a physician, he went in 1769 to the University of Edinburgh, and studied medicine there for three years under the immediate direction of the illustrious Cullen. In 1772 he came to London, and attended the lectures of his uncle's learned friends, Dr. W. Hunter and Dr. G. Fordyce. About the same time also, that he might obtain an English degree in physic, though he was then nearly twenty-three years old, he entered at Benet College, Cambridge. In 1780, several years before he received his doctor's degree, he was elected physician to St. Bartholomew's Hospital; and about the same time may be placed the commencement of his private medical practice. In 1792 he was chosen

physician to Christ's Hospital; and in the following year, his private practice being now considerable, he resigned the office of Physician to St. Bartholomew's Hospital. His office at Christ's Hospital demanded but little of his time, and was therefore retained by him several years longer.

By the death of Dr. Warren, which took place in June, 1797, Dr. Pitcairn was placed at the head of his profession in London. One or two other physicians possibly derived as much pecuniary emolument from the practice of medicine as himself; but certainly no other one was so frequently requested by his brethren to afford his aid in cases of difficulty. But this prosperous state did not endure long. In the autumn of the same year he fell from his horse, and bruised his side. Shortly after, his heart began to beat with violence, and his attention was more particularly directed to this symptom, as it had occurred in one of his brothers, likewise in consequence of a fall, whose heart, after death, was found considerably enlarged. He continued, however, to follow his profession till February in the following year, when he was attacked with a hæmorrhage from his lungs. From this he recovered after some time so far as to be enabled to resume the exercise of his profession; but the same disease having recurred in summer, he embarked in September for Lisbon. During a stay of more than eighteen months in Portugal he had no return of the hæmorrhage, in consequence of which he ventured to come back to this country in May, 1800. He was still feeble, and his heart was still beating too forcibly; he for some time, therefore, declined altogether engaging in medical practice. Afterwards, as his own health improved, he began to receive patients at his house; then to meet other physicians in consultation at the houses of their patients; and at length, after an interval of several years, to undertake the entire care of sick persons at their own homes, except during four months in the latter part of the year, which he spent almost wholly in the country. In the meantime, however, the palpitation of his heart continued; on which account he for a long time lived very abstemiously, drinking only water, and abstaining almost entirely from animal food. But, as the beating did not increase, and no other sign of a diseased heart existed, and as he found a vegetable diet to produce in him much flatulence, about a year or two before his death he began to eat moderately of animal food once a day, and to take sometimes after dinner a single glass of wine diluted with water. Under this change of regimen his appearance altered considerably, and during the last six months of his life he frequently received the congratulations of his friends on the improvement which his health had undergone. Disregarding the advice given by one of the masters of his art, "*Si plenior aliquis, et speciosior, et coloratior, factus est, suspecta habere bona sua debet,*" he seemed to look upon his increased strength as a permanent acquisition, and as chiefly valuable from enabling him to bear an increase of professional labour. In the course of the month of March, for instance, he rose several times from his bed soon after midnight, and travelled between twenty and thirty miles before morning, to visit a patient. From these exertions, however, he appeared to suffer no immediate injury. But about the beginning of April he found that he was heated by his single glass of wine, though diluted largely with water, and therefore discontinued it. On the 13th he felt a soreness in his throat; but he thought so lightly of it, that he continued his professional visits during that and the two following days. In the night of the 15th his throat became worse, in consequence of which he was copiously bled at his own desire, and had a large blister applied over his throat; but the irritation occasioned by the latter remedy was so distressing to him that it was removed before its intended effect was fully produced. On the evening of the 16th Dr. Baillie called upon him, without knowing that he was ill; and having heard the history of his ailment, and an account of the remedies employed, he entirely approved of what had been done. At this time Dr. Baillie observed no symptom which indicated danger. The disease becoming more violent in the course of the night, a considerable number of leeches were applied to the throat early in the morning. Dr. Baillie visited him at 11 o'clock in the forenoon. His countenance was now sunk, his pulse feeble and unequal, his breathing laborious, and his voice almost lost, from the swollen state of the parts concerned in its formation. In this state he wrote upon a piece of paper that he conceived his windpipe to be the principal seat of the disease, and that this was the Croup. Mr. Home was also present; and it was agreed that an attempt should be made to give relief by wounding the tonsils. This was accordingly done; some blood issued, but nothing purulent. Both the patient, however, and those about him, conceived that he had derived benefit from the operation. Dr. Baillie saw him again between 4 and 5 o'clock in the afternoon, and thought his situation much improved; for the pulse was now equal and more firm, and his general appearance indicated less de-

bility and distress. Under this persuasion he left him, having previously agreed to return at 10 in the evening, when he was to meet in consultation Mr. Home and another physician who had long been intimate with his patient. A little before Dr. Baillie had paid the visit just mentioned, a slight drowsiness had come on, and this symptom rather increased after his departure. But nothing more remarkable occurred till near 8 o'clock, when the patient's breathing became suddenly more difficult. About 20 minutes after this he died.

The body was examined the second day after death by Mr. Home, Dr. Baillie, and Dr. Wells. The throat and tongue were found much inflamed and swollen. The inner membrane of the windpipe was also found inflamed, but altogether free from that preternatural coating which occurs in croup. The heart and lungs were entirely sound; but the great artery, close to its origin, was somewhat diseased; sufficiently, perhaps, to occasion in a person of an irritable frame an increased force in the pulsations of the heart, though apparently not in such a degree as to affect the duration of life. On the 25th his corpse was deposited in a vault in the church of St. Bartholomew, near Smithfield, which contained the remains of his father and uncle.

Dr. D. Pitcairn had five brothers; one of them died young; three others, all of them officers in his Majesty's service, died after they were men; the youngest, a counsellor at law, survives him. He had four sisters, all of whom have been married and are alive. His mother also still lives, and is in her seventy-ninth year. In 1781 he married Elizabeth, the only daughter of William Almack, Esq., of London, and a niece of his preceptor, Dr. Cullen, but had no issue. She likewise survives him.

His person was tall and erect, but of late years rather thin; his countenance during youth was a model of manly beauty, and even in advanced life was remarkably handsome. While a boy, he was noted for possessing a grave and manly manner, connected with much sweetness of disposition. These qualities, added to considerable bodily strength and courage, gave him great influence over his playfellows. But, though of a studious turn, he did not acquire knowledge at school as quickly as some of his companions. His memory, however, was strong, and his judgment sound; whatever, therefore, he learned was retained, and well assorted; so that in time he excelled most of those who had once been regarded his superiors. His knowledge of history and geography, from the strength of his memory, was particularly accurate.

Few persons ever gained, without any direct effort to this end, so extensive an acquaintance with the various orders of society. His education began at the largest school in Great Britain. He afterwards studied for several years at each of the great Universities of Glasgow, Edinburgh, and Cambridge, and attended the principal lectures upon medicine in London. While a young man in London, he lived with his uncle, who had many friends, and frequently entertained them at his house. He resided many years in Lincoln's Inn Fields; and, while there, associated daily with gentlemen of the law. He was early admitted a Fellow of the Royal and Antiquarian Societies; and hence knew many learned men, in addition to those of his own profession. He was fond of country sports and athletic games, particularly the Scottish one named golf, which carried him among other sets of men. He had a taste also for the fine arts; in consequence of which, he became acquainted with many of the professors of them; and his employment as a physician in the largest hospital in the kingdom, and in private, made known to him a very great number of persons of every rank and description in life. From such opportunities, and an original turn for the observation of character, he obtained a most extensive knowledge of human nature, and an infinite fund of stories and anecdotes, which, when at ease among his friends, he used to relate in the happiest way. None of his stories, however, related to himself; indeed, he scarcely ever spoke of himself to his most intimate friends; no doubt from a wish to avoid a fault he saw so frequently committed by others. In conversation he shunned dispute. When he dissented from others he either declared his opinion in a few words or remained altogether silent. With literary men his value as a companion was considerably increased by his judgment in selecting, and lively mode of repeating, passages from new works of taste, most of which he read immediately after they were published. But, though he had lived so much in society, he never entirely lost a natural shyness of manner, which was more observable at some times than at others. This was often imputed by those who did not know him to pride; though, in truth, it seemed to arise from a diffidence of his own merit. As he advanced in years his manners became less reserved to strangers; for, to his friends, they had always been frank and affectionate.

His feelings were warm, and he was sometimes betrayed by them into little improprieties; but this disadvantage was greatly outweighed by the energy which was hence given to his character, and the interest which he hence took in the happiness of others. It may be regarded, perhaps, as no considerable title to praise, that he behaved with the utmost kindness and generosity towards his numerous relations. But his endeavours to serve were not confined to these. He was ever ready to assist his friends in their pursuits, not only by his advice, but by his influence with others, and the sacrifice of his time; to say nothing of other aids which he frequently furnished. Like other men of warm tempers, he was apt to bestow upon his present pursuits more than their due importance; and, as increase of years and professional employment, together with great varieties in the state of his health, necessarily produced alterations in his views of life, he was hence thought by some to be of a changeable disposition. But this was never said respecting his attachment to persons. He continued to the last, loving his first friends, and was, in return, most cordially beloved by them.

His manner, as a physician, was simple, gentle, and dignified, and always sufficiently cheerful to encourage hope, without offending by its incongruity with the scene about him. From his kindness of heart, he was frequently led to give more attention to his patients than could well be demanded from a physician; and as this evidently sprang from no interested motive, he often acquired considerable influence with those whom he had attended during sickness. No physician, indeed, of his rank in London perhaps ever exercised his profession to such a degree gratuitously. His behaviour to other physicians was highly candid and liberal, and he most studiously avoided the slightest appearance of interfering in their professional concerns. Such conduct is, no doubt, recommended by its ultimate utility; but in him it arose from a native sense of honour, that appeared in every other transaction of his life.

As he attended very carefully to the symptoms of diseases, in the order and degree in which they occur in nature, he had, from this source, and the excellence of his memory, acquired great practical knowledge of his profession. He had, in consequence, also made many original observations upon the history and treatment of diseases. He was, for instance, the first who took notice of the connection between rheumatism of the external parts of the body, and a certain affection of the heart, which he hence called rheumatism of that organ. Since it was mentioned by him, numerous examples of it have been seen by others, which puts the justness of the observation beyond doubt; though no trace of it exists in any author prior to Dr. Baillie, to whom he had communicated it. He never published any of his observations himself; but several, besides that which has just been spoken of, have been given to the world by others. About two years before his death he told the author of this account that he had a great desire to write upon gout; but there is no reason to believe that he ever accomplished it.

He never long enjoyed very good health from the time of his commencing to practise physic in London. For, not to repeat what has already been said respecting his disorders, he was, during many years of the first part of his residence here, much subject to violent headaches. He twice laboured under severe agues; and suffered many attacks of inflammatory sore throat. But none of his ailments made any considerable permanent impression upon his external appearance; for, immediately before his death, no person would have supposed, from seeing him, that his health had ever been bad, or that he had attained the age of nearly sixty years.

Notes by a Country G.P.



DURING the last four months there have been allotted to me patients whose cases, to my poor rural mind, seem interesting, and at any rate stand above my usual dead level; and as so many of the readers of the JOURNAL were wont in my student days to oftentimes wish for news of cases such as they might meet with in general practice, I feel justified in trying to supply a few. I need scarcely say they are only what *might* be met with; what *must* be met with are chronic rheumatism and dyspepsia in all their protean forms. Nevertheless the cases are in the "most middle country."

CASE 1. Epilepsy in labour.—Mrs. M—, æt. 35, 10-para, said to be always hysterical in labour, the hysterics appearing at the fifth pregnancy. On May 19th she was having first stage pains. Found with

a paroxysmal laryngeal cough, very suggestive of hysteria. During my absence had three fits judged to be hysterical. In evening a convulsive attack, marked by general rigidity, but during it conjunctive were sensitive; the attack ceased on inhalation of strong ammonia and application of chloroform on lint to nape of neck. No œdema and no albuminuria. Child alive and in the first position of vertex.

May 20th.—Several fits, which were obviously *not* hysterical, not preceded by definite aura or cry; patient getting so exhausted that membranes were punctured through as the size of a shilling.

21st.—Fits very frequent; treated by chloroform. Epileptoid in character. Urine 1006; no albumen; no casts; three pints in twenty-four hours. Champetiere's bag introduced and inflated fully.

Early in morning of 22nd, the head not having engaged after the bag had been passed, although the pelvis was quite roomy, and as the fits were continuing, I delivered her by forceps. There was considerable hæmorrhage owing to the almost inert state of the uterus, which was ceasing work. During the next four days she had three fits, and I found out subsequently she was subject to epilepsy.

We are told not to deliver in the absence of pains, or except in obviously primary inertia. In this case I had eclampsia in my mind, and had tried to give her some sleep without success. She was getting worn out by fits and feeble pains; the os was sufficiently dilatable, and I felt myself capable of controlling post-partum hæmorrhage. The case was not easy of diagnosis because there was a distinct hysterical element, and I found myself often wondering whether I was not giving chloroform for hysteria. She never had nor has had any albuminuria since. She lived six miles from my house.

CASE 2. Pseudocyesis.—Mrs. T—, æt. 48, 5-para, December, 1897. Considered herself seven months pregnant; felt movements three months ago. Has had hæmorrhage on and off for last two months. Now feels pains like labour. On examination of abdomen resonance everywhere and flatulent. P. V. Cervix fixed, indurated, irregular; through it comes a foul, blackish discharge. Diagnosis made, from subsequent examination, of new growth. Patient would not credit diagnosis of "not pregnant," and sent for a "rival."

CASE 3. Placenta prævia.—Mrs. S—, æt. 35, 2-para, saw a doctor for bleeding at sixth month of pregnancy. When "called in" I found cervix particularly "boggy," and an "uncanny" feeling about region of anterior fornix; no pulsation. Os admitted finger. Told to lie up for two weeks, and to send at once if any bleeding occurred before that. She was given a mixture of ergot and Acid. Sulph. Dil. and opium. Bleeding had not been profuse. Six weeks after, she apparently having entirely dismissed the subject from her mind, and having never obeyed instructions, I found her dying, lying on the floor in a pool of blood. A leg was got down rapidly, but it was useless as there was no more blood to stop. She never showed a sign of life. She was ironing when the hæmorrhage occurred. I have never heard of so rapid a termination. There was no question of the prævia. The case shows the necessity of very carefully considering before we decide not to induce labour where placenta prævia is suspected in a patient not near at hand. She lived close at hand.

CASE 4. Miss C—, æt. 30, complained of diplopia and consequences of false projection of the image, severe nocturnal pains in the region of the sciatic nerves, and round the chest about the level of the sixth ribs. There is divergent strabismus of right eye, but no paralysis of movement (this seems probably due to fact that in right eye the V. = 0); the pupils are not equal, and only the left reacts to accommodation. Knee-jerks are absent, and there is well-marked optic atrophy in both eyes. Six months previously she had been treated at the Middlesex Hospital, from which I learnt that there was then no optic atrophy, and diagnosis was early tabes dorsalis. Three years ago she is said to have had influenza. I have never seen a clear case of tabes dorsalis in a woman before, and had I not been on the alert might easily have missed the diagnosis of this one, and have treated her for sciatica or some more common complaint. Curiously enough, after taking twelve doses of Liq. Arsenicalis *mv* she has had no recurrence of her nocturnal pains during the last two months. One week ago (July 3rd) she had a syncopal attack.

CASE 5. Adenoids and medical treatment.—Master H—, æt. 14, last Christmas had acute tonsillitis, followed by otorrhœa from right ear. Tonsils quieted down to what is probably their natural enlarged size. He remained deaf, and on further examination proved to have adenoids. The suppurative was treated much as usual, and three months ago I advised that I should remove the adenoids. Being rather strongly asked to try other means first, for the last two months I have once or twice weekly syringed through the nostrils solution

of borax and ammonia chloride Politzerised, and made him perform "Valsalva" with the vapour Tr. Benzoin. Co. in his mouth, putting pressure to the ear with the ruptured membrane. He has also been taking Syrup. Ferri Phosph. Co. As a result of this treatment, or rather during its process, the watch-hearing of the left ear has increased from three inches to twenty-one inches, whilst the right ear has improved from application to six inches. I do not think this improvement can be accounted for merely by the subsidence of an inflammatory condition, because there was for more than a month afterwards no obvious improvement. The adenoids are still present, but the boy's expression is less "batrachian."

CASE 6. *Ovarian cyst*.—Mrs. S—, æt. 70, had a characteristic ovarian cyst which, notwithstanding her general good health, she refused to have operated upon, despite my representations of her final discomfort. Six months afterwards the tumour was causing her the most urgent distress—dyspnoea, œdema of legs, vomiting, and considerable pain. She requested me to tap it, which I did with all antiseptic precautions by plunging a fair-sized operating needle (No. 12 catheter) through a one-inch incision and removing a pint of blackish-green gelatinous fluid. She died on the fourth day afterwards, merely going out like a burned candle, having no symptoms of anything special, and thanking me for her relief.

CASE 7. *Chorea and delirium tremens*.—Mrs. P—, æt. 55, April 13th, has all the appearances of a chronic alcoholic with bronchitis. Six weeks ago noticed weakness and tremor of the left arm; now there are characteristic fidgety movements everywhere and no paralysis, but alcoholic tremors enter into the case. There is no history nor family history of chorea nor of acute rheumatism.

May 1st.—The movements are quite characteristic of chorea. She has improved under bromide of ammonia ʒij daily, and a pill of valerianate of zinc, with gradually diminishing alcohol.

20th.—Bromide has reached ʒiij, the alcohol has been reduced to a minimum, and she seemed much better. There is no albuminuria; mental condition fair.

22nd.—Delusions of snakes, &c., and she became violent from terror.

23rd.—No movements now, but her mind seems unhinged by her fright. From 23rd to 25th she was sleepless and terrified, except under hyoscyne gr. ʒss.

On the 26th she became more and more comatose and died. The case I consider interesting from the fact that chorea developed after the age of fifty. Delirium tremens supervened some time after removal of alcohol and during the exhibition of bromide ʒiij. It was her first attack. Insanity seemed the result of fright, and the absence of a family history of chorea prevents this from being clearly grouped with Huntington's chorea.

CASE 8. *Glycosuria*.—Rev. J. B—, æt. 55, April 25th, for the last four weeks has had a pain in region of left sixth rib, from the spine outwards, and loss of flesh, attributed to a fall. Complains also of balanitis and pains in both groins. He had been treated by plasters and liniments, &c., but seemed to get worse. On examination the spleen could be felt and seemed the tender spot, and his abdomen was pendulous. Ordered an abdominal belt and a lotion for the balanitis. Opportunity of examining urine lost on two occasions by the fracture of the bottle containing it.

May 1st.—He went to London, where some one told him he was suffering from the spleen, and abundance of sugar discovered. This cleared up the cause of balanitis, and gave an indication for treatment. The sugar disappears now at once on an antidiabetic diet, and does not return when he is taking Hovis bread, any wines, milk, and one potato daily; but reappears at once with sugar, fruit, asparagus, and pastry. Despite the absence of sugar the dull aching pain continues, and (June 2nd) has extended along the left internal saphenous nerve. These pains disappear quickly with morph. gr. ʒ t. d. s., and reappear on its removal. Wasting continues. The case must be considered one of diabetic peripheral neuritis, and I am doubtful whether the wasting does not demand a carbohydrate diet. Morphine does not appear to affect the sugar.

CASE 9. *Tachycardia after typhoid fever*.—Mr. V—, æt. 29, May 2nd, says that ever since typhoid fever two years ago his heart has troubled him. He is anemic, and his apex-beat is one and a half inches external to the nipple line; after exertion one can hear a systolic bruit, and it has characters of one due to mitral disease. There is occasional intermittence of which he is conscious, but it is the continued rapid beating that worries him. Put on Ferri & Amm. Cit. gr. xxx, Tr. Convallariæ ʒx daily.

June 1st.—He is much better, only gets the rapid beating on exertion; anemia is going.

20th.—Considers himself cured. Apex-beat is three-quarters of an inch, or breadth of my index finger, outside left nipple line. I

used often to wonder when at St. Bart.'s whether I should ever diagnose during life Zenker's degeneration!

CASE 10. *Sciatica*.—D—, æt. 40, March 20th, sat on edge of a seat which was damp, with left leg crossed over right, for a long wet journey.

March 22nd.—Acute typical sciatica, which made him cry out. Never has had rheumatism, or malaria, or gout. He is a strong, healthy farm labourer. Put on Sod. Salicylatis gr. xx quartis horis, and poultices ordered all over the affected right leg.

April 1st.—Pain disappears slowly; blisters the size of a five-shilling piece applied in succession from sciatic notch to heel, and the medicine repeated.

4th.—Leg is anæsthetic and weak. Nothing abnormal has ever been felt in abdomen.

May 2nd.—Leg has continued weak, painful, and anæsthetic in patches behind. Put on quinine gr. x daily, faradism having been tried on alternate days since April 4th.

July 1st.—From the first day of taking quinine he has had no more pain, and now the leg is nearly well. I have now seen three cases which the result showed to be pure sciatica, in which there were weakness and anæsthesia. I look upon quinine almost as a specific in cases of no particular ætiology. This district was once malarial.

A Case of Pyopneumothorax following Abscess of the Lung.



BSCESS of the lung appears to but rarely result in pyopneumothorax. Sausser's statistics as to the causation of pneumothorax give abscess of the lung as the occasion of this accident in but one out of 131 cases, whilst phthisis was responsible for eighty-one. Under the circumstances the following case appears worthy of record, especially as it presented certain difficulties of diagnosis until the occurrence of the pneumothorax.

A. A., æt. 4, admitted to Luke Ward on March 28th, 1898, under care of Dr. Gee.

History of present condition.—Eleven months ago he had measles, from which he recovered. For the past fourteen days he has been subject to attacks of coughing, bringing up a great deal of mucus. He has not been heard to whoop.

On March 26th he vomited for the first time, seemed worse, and was very languid. He coughed much and brought up green phlegm. He would eat nothing. Bowels were open this day, but not since. Has had no diarrhœa.

On March 27th he was very restless and would not sleep nor take medicine. Did not complain of headache.

Present condition.—Thin, miserable little specimen; smells offensively; irritable, restless, and peevish to a degree—tossing about in bed, refusing to remain covered by the clothes. Will take neither food nor medicine; is nasal fed with much resistance, and usually vomits the food shortly after. Coughs frequently, but the paroxysms are feeble and there is no whoop. A quantity of greenish sputa is brought up now and again. Appears to suffer from no headache. There is no squint. *Tache cérébrale* certainly not marked. Temperature remains subnormal. Pupils equal and react to light. No success as yet in attempts to see optic discs. No otorrhœa. Tongue furred. Chest: râles and rhonchi over both lungs. Heart, as far as can be made out, natural. Pulse almost impossible to feel on account of peevishness—rate about 140. Abdomen is retracted. Has passed no urine during the eighteen hours in hospital. Both knee-jerks obtained.

March 31st.—Improved; still vomits a good deal. Very drowsy at times, at others very restless and peevish. Distinct whoop noticed to-day. Bowels open but no diarrhœa. Attempts to see optic discs still unsuccessful.

April 1st.—Temperature rose last night, and to-day is fluctuating between 100° and 101°.

April 5th.—Optic discs appear swollen and vessels engorged, the edge of the discs a little "frayed." The last day or two the child has been worse. Temperature is rising, and the respirations are more rapid. Mouth remains in a very dirty state despite treatment. Has not vomited for a day and a half. Signs in lungs as before.

April 7th.—Temperature is still high (102.4° — 104.6°). Widal's reaction yielded a negative result. Moist sounds in lungs have increased, and at the right base, internal to the scapula, impairment, bronchial breathing, and bronchophony have appeared.

April 8th.—Signs in chest as above.

April 9th.—Signs in chest quite indefinite again.

April 10th.—Called at 6.45 a.m. and found the child cyanosed, breathing very rapidly—72,—with the following signs: Right chest immobile, distended, resonant. Breath and voice-sounds amphoric, and a clear bell sound is heard. Left chest: Heart impulse, fluttering, half an inch outside the nipple line. There is inspiratory recession of the intercostal spaces on this side. This condition has apparently not produced any sudden symptoms; the child had gradually got worse during the night.

12 noon.—Child cyanosed and collapsed. Breath has heavy, sweet, earthy odour. Percussion note over right chest highly tympanitic.

2.30 p.m.—Patient in a condition of urgent dyspnoea. Paracentesis of the chest was performed without avail, and the child died at 2.35.

Post-mortem examination.—April 11th.—Poorly-nourished child. No evidence of any meningitis. No abscess in temporo-sphenoidal lobe or cerebellum. Both tympanic membranes perforated, a little pus in the right tympanum. Hard wax in external ear; no discoloration over temporal bone, no pus in mastoid cells.

Lungs: Weight of each 50 oz.; collapsed; pus in right pleural cavity. Surface of lung covered with greenish purulent liquid and a layer of lymph. The pus was offensive. In the lower lobe of each lung was an abscess cavity of considerable size. That in the right lung communicated by a ragged opening with the pleura, which was full of air. No signs of tubercular consolidation.

Nothing abnormal was discovered elsewhere in the body.

Remarks.—On admission the child's general condition pointed to tubercular meningitis, but after a day or two the severity of the pyrexia was strongly against this conclusion. The primary trouble was almost certainly the otitis media. Though the peculiarly offensive odour of the child pointed strongly to this condition, the diagnosis could never be made because his extreme fractiousness prevented a proper examination. There was never any otorrhoea while under observation. It is interesting to note that, beyond the transient evidence of consolidation in the base of the right lung, the signs in the chest were quite indefinite till the pneumothorax occurred.

Notes.

THE Winter Session begins on Monday, October 3rd, and on October 4th the Annual Dinner of Old Students will take place in the Great Hall. Sir William Turner will occupy the chair. Mr. Bruce Clarke is the Secretary for the Dinner, and to him all communications on the subject should be addressed.

* * *

THE examination for the Open Entrance Scholarships in Science, the Preliminary Scientific Exhibition, and the Jeaffreson Exhibition will begin on Tuesday, September 27th.

* * *

WE may again remind our readers that the Introductory Address of the Abernethian Society will be given on Thursday, October 6th, by Sir Thomas Smith, Consulting Surgeon to the Hospital. All past and present members and their friends are invited to attend.

* * *

MR. J. G. FORBES has been appointed Assistant Demonstrator in Pathology.

MR. P. J. CAMMIDGE has been elected Treasurer's Research Student in Pathology.

* * *

DR. NEILD COOK, Medical Officer of Health for Calcutta, was entertained at dinner on Tuesday, August 9th, by the medical officers specially deputed for plague duty. References were made in most cordial terms to Dr. Cook's energy and ability in dealing with the dreaded epidemic. Surgeon-Colonel Hendley, Inspector-General of Civil Hospitals, himself a Bart.'s man, made an important speech on the necessary preventive measures. The *Englishman* for Thursday, August 11th, commenting on the speeches in a leading article, points out that "they once and for all sweep away the insinuations that have been made regarding friction in the Health Office. There were present all the medical officers who are in any way connected with the stamping out of the disease in Calcutta, and their testimony as to the unceasing vigilance and untiring energy of the Health Officer should not be allowed to pass unrecorded."

* * *

WE have received from Dr. Black Jones, Resident Physician to the Llangammarch Wells Spa, in Breconshire, two interesting pamphlets calling attention to the advantages of Llangammarch Wells as a health resort. The special value of the waters at this spa is that they contain barium chloride to the extent of over six grains per gallon. As this is a drug which has recently attracted favorable notice in cardiac therapeutics, and as the Wells are both easy of access and pleasantly situated, it is to be expected that the spa will become increasingly popular. It would be an enormous boon to many patients, and we may add to many practitioners, to have such health resorts developed in this country. The fatigue of long journeys and much heavy expense would thus be obviated.

Amalgamated Clubs.

CRICKET CLUB.

Cup Tie—Semi-Final.

ST. BART.'S v. ST. THOMAS'S.

In this match two drawn games were played before Bart.'s were able to claim the victory. On the first two occasions Bart.'s were unfortunate in losing the toss, and consequently had to play for a draw each time with no prospect of winning. In the first match the advantage was, owing to the good batting of Greaves (not out 103) and Brunner (65), with us; while on the second occasion an invaluable stand by Scoones and Orton, which lasted over an hour, alone saved us from defeat. Luck, however, was on our side in the third match, as winning the toss and batting on a good wicket, Bart.'s put together a total of 289, the feature of the innings being a fine 121 by Sale. Against this total St. Thomas's were only able to reply with 160. Sale with 3 for 27; and Pank 3 for 67 being the most successful bowlers.

ST. BART.'S v. ST. THOMAS'S. 1st Match.

SCORES.

ST. THOMAS'S.		ST. BART.'S.	
H. M. Harwood, c Boyle, b Greaves	34	W. H. Randolph, c Adams, b Henderson	2
T. B. Henderson, c Boyle, b Sale	94	J. A. Willett, c Henderson, b Mills	26
T. H. Whitehead, b Greaves	18	H. S. Greaves, not out	103
F. M. Bingham, b Greaves	2	F. E. Brunner, b Gosling	65
T. W. Paterson, 1b w, b Sale	6	L. B. Bigg, b Gosling	0
H. Wheelwright, 1b w, b Sale	22	H. E. Scoones, not out	6
L. H. Badcock, b Rose	37	E. F. Rose	
E. V. Gosling, c Brunner, b Willett	0	E. Talbot	
J. E. Adams, not out	26	J. C. Sale	did not bat.
T. A. King, b Rose	3	H. W. Pank	
O. Mills, c and b Sale	21	H. E. G. Boyle	
Extras	7	Extras	13
Total	270	Total	215

ST. BART.'S v. ST. THOMAS'S. 2nd Match.

SCORES.

ST. THOMAS'S.		ST. BART.'S.	
T. B. Henderson, b Rose	22	J. A. Willett, b Henderson	37
H. M. Harwood, c Orton, b Rose	27	E. F. Rose, run out	16
T. H. Whitehead, c Pank, b Greaves	67	H. S. Greaves, b Mills	8
J. E. Adams, b Rose	16	F. E. Brunner, b Henderson	2
H. Wheelwright, c Turner, b Pank	0	H. E. Scoones, b Henderson	35
E. W. Hutton, c Bigg, b Pank	36	L. B. Bigg, b Gosling	30
L. H. Badcock, c and b Greaves	87	L. Orton, not out	32
F. M. Bingham, c Bigg, b Willett	20	E. Talbot, b Henderson	0
E. V. Gosling, c Pank, b Greaves	10	C. H. Turner	
A. E. Martin, c Pank, b Greaves	17	W. H. Randolph	did not bat.
O. Mills, not out	0	H. W. Pank	
Extras	14	Extras	30
Total	316	Total (7 wks.)	190

BOWLING ANALYSIS.

	Overs.	Maidens.	Runs.	Wickets.
Rose	26	6	98	3
Pank	32	7	104	2
Greaves	17	3	53	4
Willett	11	3	25	1
Turner	3	0	19	0
Talbot	3	0	10	0

ST. BART.'S v. ST. THOMAS'S. 3rd Match.

SCORES.

ST. BART.'S.		ST. THOMAS'S.	
E. F. Rose, c Martin, b Hutton	46	T. B. Henderson, c Pank, b Rose	21
J. A. Willett, c Whitehead, b Henderson	12	H. M. Harwood, c Brunner, b Rose	6
H. S. Greaves, c Adams, b Henderson	18	T. H. Whitehead, c and b Pank	49
F. E. Brunner, c Harwood, b Henderson	0	F. M. Bingham, b Pank	10
J. C. Sale, c Henderson, b Gosling	121	L. H. Badcock, b Greaves	23
H. E. Scoones, c Adams, b Henderson	44	E. W. Hutton, b Greaves	4
L. Orton, b Gosling	0	H. Wheelwright, 1b w, b Pank	5
L. Bigg, b Henderson	4	J. E. Adams, 1b w, b Sale	7
H. E. G. Boyle, c Whitehead, b Gosling	5	E. V. Gosling, 1b w, b Sale	0
C. H. Turner, c Gosling, b Henderson	4	A. E. Martin, b Sale	24
H. W. Pank, not out	8	O. Mills, not out	9
Extras	27	Extras	3
Total	289	Total	160

BOWLING ANALYSIS.

	Overs.	Maidens.	Runs.	Wickets.
Pank	24	5	67	3
Rose	15	2	35	2
Greaves	12	4	28	2
Sale	33	0	27	3

ST. BART.'S v. R.I.E.C.

The return match with this club was played at Cooper's Hill, the result being an easy win for Bart's, who ran up 319 for the loss of one wicket. Sale showed us some of his old form in a sound innings of 67, while Willett and Greaves both topped the century, remaining undefeated when the innings was declared closed. Against such a total as this the home side could do little, being got rid of for 144 owing to the good bowling of Rose and Greaves.

SCORES.

ST. BART.'S.		R.I.E.C.	
J. A. Willett, not out	112	H. P. Walsh, c Willett, b Stanger-Leathes	15
J. C. Sale, c Bowden-Smith, b Nigel-Jones	67	H. Tresawna, b Greaves	38
H. S. Greaves, not out	101	Rev. H. Bowden-Smith, b Sale	25
F. E. Brunner		G. F. Adams, c Pickering, b Greaves	2
E. F. Rose		M. E. Nigel-Jones, b Rose	31
L. B. Bigg		H. E. Fleming, b Greaves	0
H. E. Scoones		G. N. Dicken, c Willett, b Rose	5
L. Orton		F. St. C. Farran, b Rose	0
H. J. Pickering	did not bat.	A. T. Bayley, b Rose	0
C. H. Turner		J. G. Berrie, not out	11
H. E. G. Boyle		H. L. Marjoribanks, c Orton, b Rose	8
H. E. Stanger-Leathes		— Singh, b Rose	0
Extras	39	Extras	9
Total (1 wkt.)	319	Total	144

BOWLING ANALYSIS.

	Overs.	Maidens.	Runs.	Wickets.
E. F. Rose	22.2	3	44	6
H. E. Stanger-Leathes	15	3	34	1
J. C. Sale	11	1	26	1
H. S. Greaves	18	6	31	3

ST. BART.'S v. SURBITON.

This match, the last of the season, was played at Surbiton, the result being a fairly even draw. Bart's went in first, and soon five wickets were down for 75. Matters at this period looked black, but with Scoones and Buck together things brightened considerably, as the next wicket did not fall until 228 runs had been scored; 43 and 100, the respective scores of these batsmen, were both well-played innings. Boyle carried out his bat for a hard-hit 20, and the innings closed at 262. With a little over an hour in which to bat, Surbiton went in and lost four wickets for 145; Richardson's not out 69 being worthy of special notice.

SCORES.

ST. BART.'S.		SURBITON.	
J. C. Sale, c Richardson, b Bailey	37	C. A. Trouncer, b Rose	26
R. Smith, b Trouncer	1	P. Castle, c Sub., b Pank	6
L. Orton, c Bailey, b Windeler	24	H. B. Richardson, not out	69
E. F. Rose, b Windeler	4	R. L. Ricketts, b Rose	
H. E. Scoones, c Davenport, b Trouncer	43	H. J. Davenport, c Sub., b Buck	31
R. Mason, 1b w, b Bailey	5		
H. Buck, b Trouncer	100		
C. H. Turner, c Davenport, b Castle	3		
H. E. Boyle, not out	20		
H. W. Pank, b Castle	10		
A Substitute, st Richardson, b Trouncer	2		
Extras	13	Extras	11
Total	262	Total (4 wks.)	145

ST. BART'S v. UNIVERSITY.

Final Cup Tie.

This match was played at Chiswick, the result being an easy win for Bart's by seven wickets. University, having won the toss, started batting, but with two exceptions—Pretty and Stanley—could do little against the fine bowling of Rose and Willett, and were dismissed for the small total of 157. Bart's started badly, their captain being obliged to retire without scoring. With Greaves and Willett in runs came at first slowly, then faster as both batsmen settled down to play in earnest. Willett was the first to go, but not before 173 runs had been scored. Greaves did not long survive, being caught while trying to drive Wood. Their 80 and 84 respectively were both capital displays of batting. University did much better in their second innings, Pretty being again to the fore with a faultless 77. Barwell 33 and Foster 37 also did good service for their side; 213 were on the board before the last batsman was dismissed. With only 83 runs to get Bart's went in a second time, and succeeded in defeating their opponents by seven wickets, Brunner 21 and Sale 17 being the "not outs." Thus Bart's become once more holders of the Cup, this being the second time in the last three seasons that they have been able to claim the coveted trophy.

It is much to be regretted that in spite of the fact that notices have been posted concerning Cup matches and full particulars as to date and ground given, the attendance on all four occasions has been very small, the number of our supporters never, we believe, having reached double figures.

SCORES.

UNIVERSITY.

1st Innings.		2nd Innings.	
H. C. Pretty, c and b Willett	68	b Rose	77
E. S. Littlejohn, c Bigg, b Rose	10	b Rose	2
A. Ricketts, c Sale, b Rose	0	c Willett, b Greaves	21
E. H. B. Stanley, b Sale	34	b Rose	1
C. H. Wood, c Orton, b Willett	10	c Willett, b Rose	0
G. Hackney, c Pank, b Rose	0	c Orton, b Rose	4
F. R. Barwell, c Greaves, b Willett	0	b Greaves	33
E. C. Foster, c Willett, b Greaves	9	c Scoones, b Pank	37
R. A. de B. Rose, not out	17	c Orton, b Rose	14
H. S. Capper, b Willett	1	run out	5
N. F. Stallard, c Bigg, b Rose	1	not out	6
Extras	4	Extras	13
Total	157	Total	213

ST. BART'S.

1st Innings.		2nd Innings.	
E. F. Rose, b Stallard	0	b Capper	22
J. A. Willett, b Stallard	80	c Stallard, b Capper	19
H. S. Greaves, c Barwell, b Wood	84	4 not out	21
F. E. Brunner, c Ricketts, b Wood	4	not out	17
J. C. Sale, lb w, b Stallard	16		
H. E. Scoones, b Pretty	8	c Ricketts, b Stallard	6
L. Orton, b Stallard	13		
L. B. Bigg, b Pretty	10		
C. H. Turner, b Pretty	5		
H. E. Boyle, b Stallard	4		
H. W. Pank, not out	16		
Extras	47	Extras	0
Total	287	Total (3 wks.)	85

BOWLING ANALYSIS.

1st Innings.	Overs.	Maidens.	Runs.	Wickets.
Pank	15	6	34	0
Rose	26.2	14	43	4
Greaves	7	0	38	1
Sale	4	1	19	1
Willett	9	5	19	4
2nd Innings.				
Willett	16	2	40	0
Rose	21	5	74	6
Greaves	18.2	6	35	2
Sale	7	1	15	0
Pank	17	6	36	1

On Tuesday, July 26th, Bart's concluded what must be considered a successful season. The list of fixtures was a strong one, including as it did Esher, Hornsey, and Hampstead. In addition to these, Guy's, Thomas's, and University were also met in the various rounds of the Inter-Hospital Cup. Of the matches played, 7 were won, 5 lost, and 3 drawn. In the Cup Ties some really good work has been done; Westminster, Guy's, Thomas's, and, in the final, University having been defeated. Of these teams Thomas's proved by far the most formidable side, two drawn games being played before any result could be arrived at. Greaves as usual has proved a tower of strength to his side, and heads the list of batting averages with 46.5. This is now the fourth consecutive season in which his name has appeared at the top of the averages. His best contributions have been not out 103 v. Thomas's, and not out 101 v. Cooper's Hill. Willett, who comes next, has done much for his side, not out 112 v. Cooper's Hill being his highest score; his batting has been most consistent. Sale, owing to illness early in the season, has not played as much as usual, but nevertheless carries off the highest individual score, 121, this season. Brunner, Bigg, and Scoones have also proved very useful. With regard to the bowling, Rose is easily first, having bowled well through the season. Greaves, also, now that he has taken seriously to bowling, has shown that a good batsman may also be a bowler. Full batting and bowling are given below.

BATTING AVERAGES.

	No. of	Not	Total	Highest	Ave-
	innings.	out.	runs.	score.	rage.
H. S. Greaves	15	2	618	103*	47.5
J. A. Willett	14	1	515	112*	38.8
J. C. Sale	11	1	320	121	32
H. E. Scoones	15	3	259	44	21.5
F. E. Brunner	14	1	271	65	20.8
L. B. Bigg	14	2	228	82*	19
L. Orton	5	1	75	32*	18.7
R. H. Randolph	9	0	155	81	17.2
E. Talbot	7	0	118	59	16.8
H. W. Pank	9	2	113	40	16.1
E. F. Rose	15	0	180	46	12
C. H. Turner	14	3	105	39	9.5
H. E. G. Boyle	11	3	75	20*	9.3

* Signifies not out.

BOWLING AVERAGES.

	Overs.	Maidens.	Runs.	Wickets.	Average.
E. F. Rose	261.2	71	725	48	15.01
H. S. Greaves	204.2	51	505	30	16.8
J. C. Sale	62.2	21	291	15	19.4
J. A. Willett	94	26	235	12	19.5
H. W. Pank	273	64	696	29	24.0
H. E. Stanger-Leathes	83	18	220	9	24.4
C. H. Turner	38	2	140	4	35

Reviews.

EPIDEMIC DIPHTHERIA: a Research into the Origin and Spread of the Disease from an International Standpoint. By ARTHUR NEWSHOLME, M.D., Medical Officer of Health of Brighton, &c. (London: Swan Sonnenschein and Co. 1898. Pp. 196. Price 7s. 6d.)

Dr. Newsholme is well known not only as the very able Medical Officer of Health of Brighton, but as an accomplished statistician. Any one who wishes to learn what valuable conclusions may be drawn even from imperfect statistics, when these are rightly and intelligently used, cannot do better than take this little volume as his model. Statistics, to be of permanent value, must be based on sufficiently comprehensive figures. Dr. Newsholme has seized upon the data of the whole civilised world for the longest available periods of time in each case, and his results are of corresponding value and interest. It is indeed surprising to find how much light is shed on conclusions derived from the statistics of one country by the corresponding figures from others, and what erroneous conclusions may easily be drawn from too parochial a survey of the subject. The facts as to epidemic prevalence of diphtheria in different cities of the world have been for the most part thrown by the author into graphic form, and are illustrated by no less than sixty elaborate diagrams, each one of which represents much labour and toilsome calculation. All are drawn to the same scale, so that a comparison

between different countries is easy. We are apt to think that we have a good deal of diphtheria in England, but our figures fade into insignificance beside those from the continent of Europe, and especially from those of North America. Comparing England with Massachusetts, our highest epidemic death-rate is not much more than half their lowest. Diphtheria appears, in fact, to be a continental rather than an insular disease. Tracing the progress of great epidemics, the figures show clearly that it spreads gradually from town to town, and in London from district to district, the obvious inference being that its spread is mainly due to direct infection from case to case. Nevertheless Dr. Newsholme brings forward a very striking and novel fact in regard to the epidemic prevalence of the disease. Epidemics appear to arise in connection with abnormally low rainfall, especially when several dry years succeed each other. This is in apparent contradiction to the well-known relation between the disease and a damp subsoil, but the contradiction is apparent rather than real, as the author shows in his concluding chapters. No more carefully compiled statistics or clearly reasoned conclusions in connection with diphtheria from the broadest point of view can be found than in this little book; and its careful study, rather than its hasty perusal, can be strongly recommended to every student of epidemiology.

THE DIAGNOSIS OF DISEASE, by J. PORTER PARKINSON, M.D., M.R.C.P. (Lond.). London: Baillière, Tindall, and Cox, price 4s.

Of many books the chief praise lies in the statement that they "supply a need." That the need is well supplied is often a secondary consideration; a badly written book will be tolerated if it fills a want. In the book before us these conditions are somewhat reversed; we have few specific objections against the contents, but we fail to see the need of such a publication. The author tells us that "if the book prove of use to students preparing for examination, and to junior practitioners of medicine," his object is accomplished. The association of these two sets of readers inclines us to say that the student who "prepares for examination" by trusting to a condensation of the diagnosis of disease to 170 pages of crown octavo is likely not only to become a junior practitioner, but to remain one. In fact, these two types of readers of medical literature are just those who will gain little good from the book, but stand the chance of gaining much harm. Thus, to take one instance, Chapter IX, on "Diseases of the Joints and Bones," begins with an account of acute rheumatism (in fourteen lines), then treats of gout (in twenty lines), and includes a paragraph on rickets. Such faulty classification as this is inevitable in a book of such brevity, but the resulting conception of either of these diseases in the mind of the student who uses the book must be strangely inadequate, to say the least. To appreciate the book at all—that is, as a short summary of the salient features of diseases—presupposes a thorough and practical acquaintance with clinical cases. But such a mental storehouse of facts as that acquaintance implies has little need of a printed catalogue, which is what the book really amounts to. We regret we cannot recommend it, for it shows many signs of careful preparation.

AIDS TO EXAMINATIONS IN SURGERY AND MEDICINE, by T. REULL ATKINSON, M.D. (London: Baillière, Tindall, and Cox. Price 2s. 6d.)

Of this book we can only say that it possesses all the drawbacks of the last-mentioned work, without any compensating advantages that we have been able to discover.

ATLAS OF CLINICAL DIAGNOSIS AND INTERNAL DISEASES, by Dr. C. JAKOB. (London: The Rebman Publishing Co., Ltd.)

The editor of this translation in the prefatory note justly observes that "there is no deficiency of books on clinical medicine;" he thinks, however, that the high standard of the illustrations is a sufficient justification for adding this book to the number already published. In this we wholly disagree with him; it is a bad principle to attempt to teach any scientific subject by means of illustrations. The book is divided into two parts, that devoted to the illustrations and the accompanying remarks, and that occupied by an epitome of diseases. The illustrations may be divided into three sections; the first part deals with clinical microscopy, and includes plates of the various urinary crystals and other deposits of blood-fibres in several diseases, and of certain colour reactions. The illustrations in themselves are excellent, but are in our opinion quite useless for teaching purposes, compared with the actual demonstrations which should be familiar to every clinical clerk. The second part comprises the normal topography of the viscera, and is an admirable feature of the book; it is a subject very much neglected by clinical teachers, and these plates might well be added to every text-book on medicine. The third part consists of diagrammatic representations of disease, and is no doubt useful as a means of recording

cases; for purposes of teaching, to the observant it is useless, to the careless misleading. Of the text, all we can say is that the translation appears good; the descriptions and therapeutic directions are so condensed as to be in many instances quite obscure. On the whole the book is not worthy of comparison with others of the same class.

Appointments.

MOLESWORTH, T. H., B.A., M.B., B.C. (Cantab.), M.R.C.S., L.R.C.P., has been appointed Senior House Surgeon to the Stockport Infirmary.

SHEARS, CHARLES H. B., M.R.C.S., L.R.C.P., Surgeon to the Liverpool Eye and Ear Infirmary, has been appointed by the Home Secretary Ophthalmic Referee for County Court Circuit 6 under the Workmen's Compensation Act.

Examinations.

UNIVERSITY OF OXFORD.—M. H. Gordon has taken the degrees of M.B. and B.Ch.

UNIVERSITY OF DURHAM.—First Examination for Degree of M.B. *Elementary Anatomy and Biology*.—P. M. Rivaz. *Elementary Anatomy*.—C. Fisher.

SOCIETY OF APOTHECARIES.—*Medicine and Forensic Medicine*.—N. Walmisley. *Midwifery*.—D. Fletcher, J. E. Griffith.

Pathological Department of the Journal.

SPECIMENS sent by subscribers only to the JOURNAL will be examined in the Pathological Laboratory, and a report furnished under the supervision of Dr. Andrews, at the following rate:

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On application to J. Russell, Museum Assistant, a set of bottles containing hardening fluids, and ready for sending away by post, can be obtained on remitting a postal order for 2s. 6d.

Marriages.

BURNETT—KILBURN.—On July 10th, at Christ Church, Totland Bay, I.W., by the Rev. E. E. Kilburn, M.A., brother of the bride, assisted by the Rev. A. M. Maynard, B.A., vicar of the parish, Frank Marsden Burnett, M.D. (Lond.), M.R.C.S., L.R.C.P., of Sevenoaks, third son of G. H. Burnett, Esq., of Hampstead, to Lila Campbell Kilburn, youngest daughter of the late Henry Ward Kilburn, Esq., of Cannon Place, Hampstead.

CRAWFORD—WILLIAMSON.—On August 31st, at the Parish Church, Harrow-on-the-Hill, by the Rev. H. Sinclair Brooke, vicar of Pembury, Kent, assisted by the Rev. F. W. Joyce, vicar of Harrow, Cyril Rodney Holtz Crawford, M.R.C.S., of Pembury, Kent, youngest son of the late Ninian Crawford and of Mrs. Crawford, of St. Leonards-on-Sea, to Lucy Phillis Williamson, second daughter of George Williamson, of Lincoln's Inn and Harrow, barrister-at-law.

ACKNOWLEDGMENTS.—*Nursing Record*, *Guy's Hospital Gazette*.

